SAMHSA'S NATIONAL CO-OCCURRING CENTER FOR EXCELLENCE

TECHNICAL ASSISTANCE/ CROSS TRAINING REQUESTOR FORM

Please complete and return this form to the COCE at: coce@samhsa.hhs.gov. If you have any questions please contact a COCE TA Specialist at 301-951-3369. Your request will be reviewed by a COCE TA Specialist, who will contact you within 5 working days of receipt of this information. All plans for technical assistance will be discussed with you and then presented for consideration and approval by the COCE Federal Project Officer.

1. Contact Information

a. Date of Request	
b. Name of Requestor	
c. Title/Position of Requestor	
d. Name of Requestor's Organization (Include Division/Branch if applicable)	
e. Address of Requestor's Organization (Include city, state, zip)	
f. Requestor's Telephone Number	
g. Requestor's Fax Number	
h. Requestor's E-mail Address	
i. Organization Web Site (if available)	

j. Organization Telephone Number (if different from Requestor)	

2. Type of Request (check all that apply)

2a. General COCE Inquiry ○
2b. Information/Materials ○
2c. Off-Site Expert Consultation ○
2d. On-Site Expert Consultation ○
2e. Training ○
2f. Speakers/Conference Presentations ○
2g. Other (specify) ○

2h. Narrative description of request

3. Requesting Organization Entity Type

	(√ box if applicable)
a. State? (If yes, go to 3b-c, if not, skip to 3d)	
b. If a State, Are you a COSIG grantee?	
c. Are you a Policy Academy grantee?	
d. Other sub-state entity	
1-County	
2-City	
3-Tribe/Tribal Organization	
4-Community Based Provider	

5-Education Provider	
6-Criminal Justice related entity	
7-Social Service Organization	
8-Public Health Provider	
9-Other (specify)	

4. Requesting Organization Information *(if request is for information only, please complete this section. For all other requests, skip to question 5)*

a. Is your agency's primary focus mental health or substance abuse (or other, please specify)?	
b. Are you primarily a treatment or administrative setting?	
c. What is the target population that your organization serves (e.g., adults, children & adolescents)?	
d. Are there specialty sub-populations that your agency focuses on (e.g., women, the homeless, criminal justice-	

involved)?	
e. Estimated number/percentage of clients served who have co-occurring disorders	Number _____ Percentage _____
f. Number of staff	
g. What percentage of staff is clinical?	
h. Is this organization independent?	
i. Total number of clients served annually. If not independent, what is the name and address of parent organization?	
j. How many locations do you operate?	

5. Requestor Agency's Authorizing Official

a. Name of CEO/Director (if different from requestor)	Name _____ If same as requestor, simply check here _____
b. Is the CEO/Director aware and supportive of the request?	

6. How Did Requestor Learn of COCE? (Check all that apply)

a. Federal Agency press release	

b. COCE marketing materials	
c. State Agency	
d. Professional Organization	
e. Provider Association	
f. Other (specify):	

7. Comments

8. Intake Information **(For COCE Purposes Only)**

Date Received	
TA Request ID#	
Authorization	**_____ Yes** **_____ No**

Action Taken	**_____ General Reply** **_____ Customized Reply** **_____ Assessment Needed** **_____ Out of Scope**
If assessment needed:	
TA Specialist Assigned	
Date Forwarded for Assessment	
For all other requests:	
Date Intake Completed	